

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-041937

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 29 Primary Registration District No. Registrar's No. 202

FILED DEC 11 1962

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CASS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>CASS</b>                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Peculiar Twp.</b>                     |  | c. CITY OR TOWN <b>HARRISONVILLE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Pleasant View Rest Home</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>201 W. Mechanics</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED<br>(Type or print) First <b>HUGO</b> Middle <b>X</b> Last <b>THEDEN</b>                  |                                  |   | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>8</b> Year <b>1962</b> |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>                               | 8. DATE OF BIRTH<br><b>4/18/1887</b>                               | 9. AGE (last birthday)<br><b>75</b>                                  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Davenport, Iowa</b> |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                                  | 13a. FATHER'S NAME<br><b>Peter Theden</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Sophia Halmon</b>                    |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Lora Etta Theden</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>James Callaway-Peculiar-mo.</b>  |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO (b) <b>Extremities clamps</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>5 yrs</b>      |   |

|   |   |  |  |
|---|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 20f. CITY, TOWN, OR LOCATION<br><b>1957 to Dec 8</b> and last saw him alive on <b>Nov 8, 1962</b>  |  |
| 21. I attended the deceased from <b>5-30</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   | 22a. SIGNATURE <b>A. E. Fensch</b> (Degree or title)   |  |
| 22b. ADDRESS <b>Harrisonville Mo</b>  |   | 22c. DATE SIGNED <b>12/8/62</b>  |  |

|  |                                |   |  |
|--|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>       | 23b. DATE<br><b>12/10/1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wells Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Peculiar-mo.</b> |
| 24. FUNERAL DIRECTOR<br><b>Atkinson-Dickey-Harrisonville-mo.</b> |                                | 25. DATE RECD. BY LOCAL REG.<br><b>12-8-62</b>              | 26. REGISTRAR'S SIGNATURE<br><b>Ray J. Sebire</b>                    |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert Atkinson

Licensed Embalmer No. 7902  
P. O. Address Haverhill, Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.